#151 Q: From PBGA's perspective we are very concerned regarding the data recently posted in the response to question #114. Our information on claims processing for TFL indicates a professional to institutional mix of 84.9% to 15.1%. The information provided in the answer would indicate a roughly 1% institutional volume. Is it possible that the institutional figure was incorrectly entered on the answer? The ratio has a significant impact on staffing, so we would like to make sure we're all proceeding under the same assumptions.

A: The numbers provided are correct. There are obviously some inpatient professional records associated with the institutional care, and these were included with the numbers for professional records. Just as in our regular TRICARE business the institutional claim volumes are less than 2 percent. If you are considering your historical TFL volumes as inpatient versus outpatient, then the inpatient (Institutional and Inpatient Professional) would be more than 1-2 %

Response to #152(3) is revised in 24 JAN 03 Update:

#152 Q: We have the following questions:

Q(1): Will the government please provide the names and locations of all current Medicare carriers and fiscal intermediaries?

A(1): TMA does not compile or maintain such a listing. This information should be obtained from the Centers for Medicare and Medicaid Services.

Q(2): Will the government please provide the formats and communication methods needed for the EDI routing of claims from the Medicare FIs and carriers to the TFL claims processing operation? Will these methods and formats change during the life of the contract?

A(2): This information is not collected or maintained by TMA. EDI formats may be obtained from the Centers for Medicare and Medicaid Services (CMS) web site at http://www.cms.gov/providers/edi/ .

Q(3): The RFP does not discuss EDI "pass through fees" from the Medicare fiscal intermediaries and carriers. Is it the Government's intent for offerors to include these fees in our fixed price per transaction? Is so, please provide any information and costs associated with these fees.

A(3): Please also refer to our responses to Questions #19 and #149. Per the Operations Manual, Chapter 22, Section 4, Paragraph 7, pass through fees (a.k.a crossover claim fees) should be submitted separately to TMA on a non-TED voucher. They should not be included in the fixed price per transaction. [Note that

"fixed price per transaction," for the purposes of this question and response, means "claim rate" as used in Section B and elsewhere in the RFP. The Government will, as a general rule, pay one claim rate payment per each TED ICN (internal control number) accepted by TMA. Also see Question/Answer #47 regarding claim rate payments.] The fees, which differ according to claim type, are established by CMS. TMA is not a party to those agreements and does not maintain records of those fees. Information can be obtained from CMS.

Q(4): As a follow-up to Question #74: If the MCSCs consider their provider fee schedules proprietary and will not provide the TDEFIC with these negotiated rates, (a) will TMA provide the provider fee schedules to TDEFIC? (b) If these are the TRICARE fee schedules, on what periodic basis is the TDEFIC required to update the TRICARE Fee schedules, how are these fee schedules delivered to TDEFIC, and is a file format for these fee schedules available to the TDEFIC pre-award?

A(4): Network discounts do not apply to TDEFIC claims. TDEFIC payments when TRICARE is primary are to be made in accordance with CMAC rates, which are provided to contractors by TMA. Please refer to the Reimbursement Manual, Chapter 5 Section 2.

Q(5): Medical necessity can be determined at the authorization level. Question 74 indicated that TDEFIC will not be responsible to issue authorizations for services. Please define the intent of this requirement Section L-14.5.1.1.1: Offeror shall describe its strategy and process(es) to ensure that care for which claims payment is made, including Mental Health care, is medically necessary and appropriate and complies with the TRICARE benefit contained in 32 CFR 199.4 and 199.5.

A(5): We assume you are actually referring to paragraph L-14.5.1.1.2. This section simply reinforces TRICARE's statutory mandate that all care, in order to be covered by TRICARE, must be medically necessary and appropriate, rather than simply equate to a procedure code.

Q(6) Amendment 0002 added claims processing for services received in a number of additional locations (Guam, Puerto Rico, etc). (a) Should the table in F-2.2 be revised to indicate the phase-in of those locations? (b) There is no reference to adding telephone services to these locations. Note Section C-3.8.4 was not altered with Amendment 0002. Are we to correct to assume that live operator phone service is not being extended to the geographic locations added?

Q(a) F-2.2 will be revised in an upcoming amendment.

Q(b) Toll-free telephone access will be required for residents of Puerto Rico. Please refer to the Policy Manual, Chapter 12, Section 11.1. The RFP will be amended to make this requirement clear.

Response to #153 Provided in 18 DEC 02 Update:

#153 Q: Section C, C-3.5.5.3. discusses HIPAA compliance. Does D.O.D. consider the contractor a covered Entity or a Business Associate under HIPAA? If considered a Covered Entity, please explain why. If considered a Business Associate, whom do you consider the Covered Entity? If TRICARE Prime or D.O.D. is the Covered Entity, is the Business Associate agreement that the contractor will be asked to sign available for review?

A: The TDEFIC contractor will be a business associate of the TRICARE Health Plan (the covered entity). The contractor may be a covered entity in its own right for other lines of business but for TRICARE, the TDEFIC contractor is a business associate. The Business Associate Agreement is currently being coordinated internally. It will be made available for review upon completion of the internal coordination process.

Response to #154 provided in 19 DEC 02 Update:

#154 Q: Will any portion of the Personal Health Information (PHI) that will be stored as part of the TRICARE for Life contract be considered part of the TRICARE eligible's "Designated Record Set"?

A: The term "designated record set" is defined in the HHS HIPAA Privacy Rule and the draft DOD Health Information Privacy Regulation at DL1.1.6 as "A group of records maintained by or for a covered entity that is the medical records and billing records about individuals maintained by or for a covered health care provider; the enrollment, payment, claims adjudication, and case or medical management records systems maintained by or for a health plan; or used, in whole or in part, by or for the covered entity to make decisions about individuals. For purposes of this paragraph, the term "record" means any item, collection or grouping of information that includes protected health information and is maintained, collected, used or disseminated by or for a covered entity." Given this definition, personal health information, including protected health information, is part of the TRICARE Health Plan's Designated Record Set under the TRICARE Dual-Eligible Fiscal Intermediary Contract.

#155 Q: Based on an 8 a.m. Eastern Standard Time start of live operator services, what is the last hour for which the contractor will be required to supply live operator services in EST?

A: Live operator services could cease at 5:00 p.m.

#156 Q: We are unclear as to the contractor's responsibilities in Program Integrity. According to TOM Chapter 22, Section 4, 3.0, "Contractor's Responsibility in Program Integrity", when the contractor receives allegation of fraudulent behavior, or any type of improper activity relating to either a beneficiary or provider submitted claim, the contractor shall forward to CMA with a copy to Office of Program Integrity, TRICARE Management Activity after verifying the claim was processed correctly. However, RFP references C-3.10 and C-3.10.1 state the contractor is to follow the guidelines set forth in 32 CFR 199.9 and TOM Chapter 14.

Is the TDEFIC contractor required to adhere to the requirements of TOM Chapter 14 which include developing or purchasing commercial anti-fraud software designed to identify probable fraudulent or abusive practices, identifying a minimum of 10 cases per year, conducting case development and action, establishing procedures for preventing and detecting fraudulent or abusive patterns, evaluation of pre- and post-payment audits, and the submission of various reports?

Additionally, if commercial fraud and abuse software is required, is layered logic and artificial intelligence a requirement for TDEFIC? If so, please describe what is meant by " layered logic"?

We recognize it may be necessary to work with TMA and other government agencies on cases under investigation. Additionally we will work with the MCSCs and address in the MOU procedures regarding provider exclusions, suspensions, and terminations and provider reinstatements.

A: The TDEFIC contractor's role in the event of suspected fraudulent or abusive behavior is more sharply circumscribed than for the MCSCs, since the TDEFIC contractor is paying in a secondary role. Primarily, it consists of making appropriate referrals to the Centers for Medicare and Medicaid Services (CMS, not CMA as stated in your question), and cooperating with their investigative efforts and any adverse actions taken as a result of those actions. In those situations where TRICARE is primary, referral and coordination will be directed to the Office of Program Integrity at TMA. The requirements for commercial antifraud software, etc., as set forth in TOM Chapter 14 do not apply.

#157 Q: TRICARE Operations Manual 6010.51-M, August 1, 2002 Chapter 1, Section 3.4 states: 95% of all telephones shall be answered within 2 rings by an Automated Response Unit (ARU). The caller shall have only two choices: transfer to an automated response unit (e.g. automated claims inquiry, recorded messages where to submit claims or correspondence. Etc.) or to an individual.

Question: If the caller selects "individual", is it acceptable to have an additional menu selection before routing the call to a Customer Service Representative?

This type of menu selection would allow an organization to utilize a product referred to as Agent Access Routing or Skill Based Routing. Agent Access Routing is an intelligent segmentation and routing solution that personalizes the routing of inbound calls based on the customer segments. Agent Access Routing intelligently handles calls based on an organizations relationship with each caller. Agent Access Routing uses business logic to personalize the routing of every inbound call according to its value by sending each call to the best agent skill set. By getting every call to the right agent skill set, an organization can create greater customer service and higher levels of customer satisfaction.

A: No additional automated screening or routing should take place after the caller has elected to speak personally with a Customer Service Representative.

#158 Q: TMA has indicated that specific volumes for dual eligibles telephone calls are not available. Given the substantial costs required for labor and equipment to implement a call center, would TMA consider providing bidders with a figure to use for bid evaluation purposes for equalizing bidders' costs.

A: Telephone call volumes are highly dependent upon the contractor's performance. Thus, provision of a figure for proposal purposes would be speculative at best and misleading at worst. We believe that offerors' "real world" expertise makes them best qualified to predict a potential call volume under TRICARE For Life. It should be noted that TRICARE For Life calls to the TRICARE Information Center have stabilized at an approximate monthly volume between 60,000 and 65,000 (these figures should be considered approximate and are not official.)

#159 Q: Given the very low volume of claims for which the TDEFIC has primary payer responsibility and the resulting limited scope of clinical review, please identify which tasks in TOM Chapter 7 regarding the interaction with the NQMC apply to the TDEFIC?

A: The interaction should be very limited. We expect that some TDEFIC claims will be included in the claim sample that will need to be drawn in connection with the Prospective Payment System for Skilled Nursing Facilities. In addition, where TRICARE is primary payer, there may be occasional medical necessity denials and appeals. As you have indicated, this should be a very low volume and the situations described are expected to occur very infrequently.

#160 Q: Since the TDEFIC contractor is paying secondary to Medicare, is there still a requirement for the TDEFIC contractor to use the TRICARE ClaimCheck software while processing professional claim?

A: No.

#161 In reference to Section C.1.1.1 the RFP states, "Revised to add claims processing for services received in Puerto Rico, Guam, Virgin Islands, American Samoa, and Northern Marianna Islands. Additionally, as referenced in Section C.3.8.4 the RFP states, "The government shall establish 24 hour, 7 days a week, nationally accessible (to include Hawaii and Alaska) telephone service, without long distance charges". There is no mention of customer service in the 1st reference, and no mention of the new territories in the 2nd.

Q: Is customer service support required for this additional claims volume? If yes, do the current RFP requirements apply (i.e. hours of operation from 8a-6p for each time zone)?

A: Customer service is required for each of these additional locations, but toll-free telephone access is only required for Puerto Rico. Please refer to the Policy Manual, Chapter 12, Section 11.1., paragraph R.5. This will be clarified via RFP amendment. Also please note that Section C of the RFP only mandates the option of access to a customer service representative "during business hours" rather than listing specific required hours.

#162 In reference to Section C.3.8.1 the RFP states, 'Marketing & educational materials will be provided by the government. Delete "TRICARE Marketing & Education Contractor" statements in this paragraph'. Additionally, in Section C.3.12.2 the RFP states, "The contractor is required to maintain a supply of all current educational material produced by the government".

Q(a): Does this mean that the TDEFIC contractor will be dealing solely with the government for all educational materials? Will the TDEFIC contractor negotiate the MOU?

A(a): The TDEFIC contractor will deal solely with the Government for all marketing and educational materials. No MOU will be needed for marketing and education.

Q(b): Will the TDEFIC contractor be able to use any material not produced by the government providing the government approves the material? (i.e. Can the TDEFIC contractor add additional material to the initial mailing?)

A(b): The contractor may seek approval to use additional material if they so desire, but the use of such additional materials will be subject to Government approval. No additional costs over and above the offeror's claim rate will be allowed for the use of such additional materials.

#163 In reference to Section C.3.8.1 the RFP states, "The government will supply the contractor with the beneficiary education materials."

Q: This only mentions beneficiary education. Will the same process be used for materials that must be sent to providers and/or Congressional Offices?

A: Yes.

#164 Q: Question 661 and your response to that question for the TNEX procurements (MDA906-02-R-0006) indicates that the PDF (Adobe Acrobat) format is acceptable, and in fact preferable, for submitting previously printed materials, including final reports, in electronic format. Please verify that this is acceptable for the TDEFIC submissions as well. Can the PDF format also be used for government supplied forms, such as the electronic version of the Standard Form 33 and Attachments L-1 & L-2.

A: Submissions in PDF format will be acceptable.

#165 Q: In Question 331 and your response to that question for the TNEX (MDA906-02-R-0006) procurement indicates that both a hard copy and electronic copy of the signed Standard Form 33 needs to be submitted. Please verify that you require this as well for the TDEFIC proposal.

A: Yes – both a signed hard copy and an electronic copy of the signed SF33 must be submitted.

#166 Q: Section L-14.6.1.1 states the "technical proposal is limited to the standards proposed by the offeror and those elements that exceed the government's requirements that are to be addressed during the oral presentation". It further states "Offeror should exercise extreme caution in preparing their written proposal as the omission of any standards may result in an unfavorable evaluation by the Government."

Q(1): We are interpreting the first statement that the offeror is to provide information on "standards proposed by the offeror" and "those elements that exceed the government's requirements" for only those standards and requirements that exceed the government's requirements. Futhermore, the offeror must do this in the technical proposal and oral presentation. Is this correct? If this is true, we are confused at the final sentence, which indicates failure to address all standards will result in an unfavorable evaluation and this would include standards listed in section F and throughout TRICARE manuals.

Q(2): We believe the Government does not wish to hear a list of every other possible standard or requirement listed in the RFP or TRICARE manuals. In lieu of receiving an exhaustive list of relatively obscure standards we believe the government wants to assume anything not stated will be met. We are confused, however by the cautionary statement at the end of this paragraph that standards not specifically mentioned in the technical proposal or oral presentations will result in an unfavorable evaluation.

Q(3): If the Government wants the offeror to list every standard inherent in Section F and TRICARE manuals this would be a considerable list, and include items such as these standards, listed at random:

- TOM Ch. 1 Section 4 2.3 Provide directories of internal zip code files to the Government no more than 12 times per calendar year.
- TOM Ch. 1 Section 4 4.2.2 provide results of the quality audit by the 45th calendar day following the close of the contract quarter.

We do not believe the government intends each such standard be listed in either the technical proposal or oral presentation. Is the government expecting the long list of standards to be reiterated and if so does this need to be in the technical proposal or oral presentation or both?

A: Your understanding of the intent is correct. What we are looking for is the specific identification of performance standards which could function as discriminators and which the offeror believes would serve to demonstrate their explicit commitment to superior performance. The offeror must identify in detail and commit in writing to meet those unique standards which they themselves propose and those Government defined standards which they explicitly commit to exceed. As for the myriad of standards contained in the TRICARE Manuals, a proposal which includes a blanket commitment to meet all the standards which are spelled out in the TRICARE Manuals would be sufficient to preclude unfavorable evaluation in regard to the language cited.